Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GULF COAST MEDICAL EVALUATIONS
1805 NORTHERN DRIVE
LEAGUE CITY TX 77573-4822

Respondent Name
TASB RISK MANAGEMENT FUND

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-11-1157-02

MFDR Date Received
December 6, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DACNB certification not required."

Amount in Dispute: $1,996.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "If EDX are performed by a technician, then that technician a) must be licensed in the state of Texas, and b) credentialed in electrodiagnostic studies, and c) be directly supervised by a physician present in the office suite. . . . Needle EMG studies should only be performed by physicians."

Response Submitted by: TASB Risk Management Fund, 12007 Research Blvd., Austin, Texas 78759-2439

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 25, 2010	Needle EMG – 95860	$249.34	$0.00
	Nerve Conduction Study – 95903	$748.64	$383.14
	Nerve Conduction Study – 95904	$598.00	$288.21
	Nerve Conduction Study – 95934	$200.20	$152.09
	Office Consultation – 99244-25	$200.00	$0.00
	TOTALS:	$1,996.18	$823.44

AMENDED FINDINGS AND DECISION

This amended findings and decision supersedes all previous decisions rendered in this medical fee dispute between the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 Texas Register 3954, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, 33 Texas Register 364, sets the reimbursement guidelines for these disputed services.
3. 22 Texas Administrative Code §75, effective December 24, 2009, 34 Texas Register 9208, sets out the scope of practice for chiropractors.
4. District Court of Travis County, 250th Judicial District No. D-1-N-GN-06-003451, Honorable Stephen Yelenosky, judge presiding, Order on cross-motions for partial summary judgment dated November 24, 2009
5. Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Opinion dated April 5, 2012
6. Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Mandate dated August 8, 2013
7. The services in dispute were reduced/denied by the respondent with these pertinent reason codes and the following explanations of denial/reduction:
   - 16 – Please submit documentation to support board certification DACNB. Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Applies to all lines. Per Amber with provider's office she was unable to obtain this information for processing of this bill.
   - 189 – Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure code. Effective January 1, 2010 the CPT consultation codes are no longer recognized by Medicare. Provider should bill with an E/M code. Per Amber she is unable to change cpt codes over the phone and requests that the bill be denied and she will resubmit a reconsideration with corrected coding.
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly. 11/17/10-Maintain original denial as the provider is not certified to perform this procedure and another doctor interpreted the results. 11/17/10 – Applies to all lines.

Issues

1. Is the rendering provider eligible to perform needle electromyography?
2. Is the rendering provider eligible to perform nerve conduction tests?
3. Is the requestor entitled to reimbursement for the nerve conduction tests?
4. Is the requestor entitled to reimbursement for the office consultation?

Findings

1. Disputed procedure code 95860 represents needle electromyography (EMG), 1 extremity. Review of the submitted documentation finds that this service was performed by Lawrence Wayne Parks, D.C. (Doctor of Chiropractic). Needle EMG involves insertion of a needle into a patient's muscle for the purpose of measuring electrical signals from that muscle.

   Litigation Background for Needle EMG and MUA

   Portions of the Texas Board of Chiropractic Examiners rules of practice were challenged by the Texas Medical Association and the Texas Medical Board in 2009. At issue was whether 22 Texas Administrative Code §75.17(a)(3), (c)(2)(D), (c)(3)(A), and (e)(2)(O) were within the scope of chiropractic practice in Texas. Specifically, the parties sought judgment on whether rules allowing Chiropractors to perform needle electromyography (EMG) and manipulation under anesthesia (MUA) were valid. On November 24, 2009, the 345th District Court issued a judgment in which presiding judge Honorable Stephen Yelenosky concluded that needle EMG and MUA exceeded the statutory scope of chiropractic practice in Texas. The Texas Board of Chiropractic Examiners appealed the district court's judgment to the Texas Court of Appeals, Third District. The

Texas Court of Appeals in Tex. Bd. Of Chiropractic Examiners v. Tex. Med. Ass'n., 375 S.W.3d 464 (Tex. App. – Austin, 2012, pet. den.) issued an opinion affirming the district court's judgment, and concluding that needle EMG and MUA services are not within the chiropractic scope-of-practice. The Chiropractic Board exhausted its appeals and on August 8, 2013, the mandate affirming the district court's judgment was issued. The mandate states "we affirm the remainder of the district court's judgment that subparts 75.17(a)(3), (c)(2)(D), (c)(3)(A), and (e)(2)(O) of the Texas Board of Chiropractic Examiners' scope-of-practice rule are void." In accordance with the Texas Court of Appeals opinion, the final mandate, and the scope of chiropractic practice requirement in 28 Texas Administrative Code §134.203(a)(6), needle EMG and MUA services may not be reimbursed.

§134.203(a)(6) provides that "Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act." However, the Division finds that disputed procedure code 95860 is not within the scope of chiropractic practice, as it is an electro-diagnostic test that involves the insertion of a needle into the patient. The carrier has supported the denial of procedure code 95860 based on the reason that the provider was not eligible to perform this service. Reimbursement cannot be recommended.

2. Disputed services billed under procedure codes 95903, 95904, and 95934 fall in the category of nerve conduction tests under applicable AMA current procedural terminology (CPT). These tests involve placing external electrodes on the skin, directly above the nerve to be tested. Such surface tests do not involve the insertion of needles. Review of the submitted documentation finds that these services were performed by Lawrence Wayne Parks, D.C. (Doctor of Chiropractic). As stated in the Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Opinion dated April 5, 2012:

   > In the second provision, paragraph(c)(3)(A), TBCE imposed certification and supervision requirements on any licenses who administered "electro-neuro diagnostic testing" that varied according to whether the testing was "surface (non-needle)" or involved the use of needles. The import or effect of paragraphs (c)(2)(D) and (c)(3)(A), as the parties agree, was that chiropractors with specified training and certification could utilize needle EMG in evaluating or examining patients. In their live petitions and summary-judgment motions, the Physician Parties challenged the validity of the two rule provisions **specifically addressing needle EMG** [emphasis added]—75.17(c)(2)(D) and (c)(3)(A) —plus the general standard regarding use of needles—75.17(a)(3).

   Surface (non-needle) tests were not at issue in the above proceedings. The Division therefore finds, pursuant to §75.17(c)(3)(A), effective December 24, 2009, 34 *Texas Register* 9208, that procedure codes 95903, 95904, and 95934 are surface tests and within the scope of chiropractic practice. The insurance carrier has failed to support its denial reasons related to board certification and eligibility of the provider to perform the disputed services. The Division concludes that the provider was eligible to perform the disputed services related to nerve conduction tests billed under procedure codes 95903, 95904, and 95934.

3. The insurance carrier further denied disputed procedure codes 95903, 95904, and 95934 with reason code 16 related to documentation. Review of the submitted nerve conduction reports finds that the documentation supports the services as billed. The respondent's denial reasons are not supported. Reimbursement is recommended.

   The disputed procedures are professional services subject to the provisions of 28 Texas Administrative Code §134.203(c) which provides that, in the absence of a contracted rate, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." For the services in dispute, the Medicare rates are calculated substituting the 2010 Division conversion factor of $54.32 for the Medicare conversion factor of $36.8729

   Review of Box 32 on the CMS-1500 finds that the services were rendered in ZIP code 77506; therefore, the Medicare fee is calculated based on the reimbursement for the Houston, Texas Medicare locality.

   The Medicare physician fee schedule rate for procedure code 95903 is $65.02. This amount divided by the Medicare conversion factor of $36.8729 and multiplied by the 2010 Division conversion factor of $54.35 is $95.7854. This amount multiplied by 4 units is $383.14

   The Medicare physician fee schedule rate for procedure code 95904 is $48.91. This amount divided by the Medicare conversion factor of $36.8729 and multiplied by the 2010 Division conversion factor of $54.35 is $72.0526. This amount multiplied by 4 units is $288.21

   The Medicare physician fee schedule rate for procedure code 95934 is $51.62. This amount divided by the Medicare conversion factor of $36.8729 and multiplied by the 2010 Division conversion factor of $54.35 is $76.0449. This amount multiplied by 2 units is $152.09

   The total reimbursement for the above services is $823.44. This amount is recommended.

4. The insurance carrier denied disputed services billed under procedure code 99244 with reason code 189 – "Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure code. Effective January 1, 2010 the CPT consultation codes are no longer recognized by Medicare. Provider should bill with an E/M code. Per Amber she is unable to change cpt codes over the phone and requests that the bill be denied and she will resubmit a reconsideration with corrected coding." 28 Texas Administrative Code §133.20(c) requires that "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." Per 28 Texas Administrative Code §134.203(b)(1), for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." §134.203(a)(5) further defines 'Medicare payment policies" to mean "reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." The health care provider billed for disputed services using procedure code 99244 for an office consultation as described in American Medical Association (AMA), Current Procedural Terminology (CPT) code set. Per Medicare payment policy, as detailed in CMS Manual System Publication 100-04 Medicare Claims Processing, Transmittal 1875, Change Request (CR) 6740, available from the CMS website at www.cms.gov, dated December 14, 2009, effective January 1, 2010, the use of consultation codes (ranges 99241-99245 and 99251-99255) was eliminated effective January 1, 2010. 28 Texas Administrative Code §134.203 (a)(8) specifies: "Whenever a component of the Medicare program is revised, use of the revised component shall be required for compliance with Division rules, and orders for professional services rendered on or after the effective date, or after the effective date of the revised component, whichever is later." As procedure code 99244 was not a valid procedure code under Medicare payment policies on the date of service, review of the submitted documentation finds that the requestor has not met the billing requirements of §134.203 and §133.20(c) for this disputed service. The insurance carrier's denial reason is supported. Reimbursement for this service is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $823.44

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $823.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	October 18, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.